

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41449

State File No. ....

FILED JAN 15 1951

BIRTH NO. ....		REG. DIST. NO. <u>2</u>		PRIMARY REG. DIST. NO. <u>5740</u>		Registrar's No. <u>91</u>	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY: (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Lingo Township</u>		c. LENGTH OF STAY (in this place) <u>7 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Lingo Township</u>		d. STREET ADDRESS (If rural, give location) <u>5 miles S. of New Cambria</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5 miles S. of New Cambria</u>				d. STREET ADDRESS (If rural, give location) <u>5 miles S. of New Cambria</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Blanche</u>		b. (Middle) <u>Etta</u>		c. (Last) <u>Hoskin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. II, 1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>July 30, 1898</u>	
9. AGE (In years last birthday) <u>52</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>II</u>		11. BIRTHPLACE (State of foreign country) <u>New Cambria, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State of foreign country) <u>New Cambria, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Samuel Kennedy</u>		13b. MOTHER'S MAIDEN NAME <u>Bridget Ann O'nealy</u>		14. NAME OF HUSBAND OR WIFE <u>Raymond E. Hoskin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>XXXX</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Anna O'Connor, New Cambria, Mo.</u>		ADDRESS <u>New Cambria, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis both lungs</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>002X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>45</u> , to <u>Dec</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Dec - 11</u> , 19 <u>50</u> , and that death occurred at <u>2 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Chas. West</u>		23b. ADDRESS <u>New Cambria Mo.</u>		23c. DATE SIGNED <u>Dec 12, 1950</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 13, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery Brookfield</u>		24d. LOCATION (City, town, or county) (State) <u>Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12/28/50</u>		REGISTRAR'S SIGNATURE <u>Josephine King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. E. Gilleland</u>		ADDRESS <u>New Cambria Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0610

12.10.51  
RECEIVED  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 1.51.245 6  
Date Filed 12.11.51

JAN 18 1951

Date Received JAN 3 1951  
DISTRICT HEALTH OFFICE #2  
District File Number  
Date Filed:

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*H. J. Gilliland*

Licensed Embalmer No. 4019

P. O. Address New Cambria Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.